

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 1000

1. PLACE OF DEATH:

County..... Charles
 City or town..... La Plata
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 6 hrs
 Hospital, institution, or street address where death occurred:
Physician's Remiel Hospital
 How long in hospital or institution?..... 6 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... MD County..... Charles
 City or town..... Indian Head
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 32 Highland Place
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

George Fred Hartman

3. (b) Social Security Number

4. Sex..... Male 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Single
 6. (b) Name of husband or wife.....
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... Nov. 1946
 8. AGE: Years..... Months..... Days..... If less than one day.....
0 0 0 6 hrs. 0 min.

9. Birthplace..... La Plata Charles, Md
 (Town, county, and state)
 10. Usual occupation..... Infant
 11. Industry or business.....
 12. Name..... John William Hartman
 13. Birthplace..... Mont Clair, Pa.
 14. Maiden name..... Virginia Elizabeth Wagner
 15. Birthplace..... Amesville Co., Md.

16. Informant..... Mrs. Virginia Hartman
 Address..... Indian Head, Md.
 17. Burial..... Date thereof..... 11-18-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... East Pikesland
 Location..... Chester County, Pa.
 18. Funeral director..... Switt & Ryan
 Address..... Waldorf, Md.
 19. 11-18-46 19.....
 (Date rec'd by registrar) Julia H. Pusey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... November 17 19 46, at 7:40 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased ~~from~~
on Nov. 17 19 46, to..... 19.....
 and that I last saw him in alive on Nov. 17 19 46
 Immediate cause of death.....
Pulmonary hemorrhage
 Due to..... Congenital heart disease
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

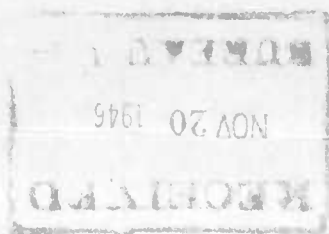
DURATION

Minutes6 hrs

Major findings of operations..... Date of op.....
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.
 22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of Injury..... Injured at work?

23. SIGNATURE..... Jan. E. MacKinnon M.D. M. D. or other
 Address..... La Plata, Md. Date signed..... 11-17-46

1-35



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1060

10975

83a

1. PLACE OF DEATH: Charles
 County.....
 City or town..... Indian Head
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 17 years
 Hospital, institution, or street address where death occurred:
 102 Couden Road
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Md. County..... Charles
 City or town..... Indian Head
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 102 Couden Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME Sally Elizabeth Henderson
 3. (b) Social Security Number

4. Sex Female
 5. Color or race White
 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife William P. Henderson
 6. (c) If alive, give age 55 years
 7. Birth date of deceased (mo., day, yr.) October 25, 1900

8. AGE: Years 46 Months 0 Days 18 If less than one day
 hrs. min.

9. Birthplace Monroeville, Va.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

12. Name George Spinks

13. Birthplace Va.

14. Maiden name Ida Brydon

15. Birthplace Va.

16. Informant Wm. P. Henderson

Address Indian Head, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 16, 1946

Cemetery or crematory Bethel Cemetery

Location Alexandria, Va.

18. Funeral director Hunt & Lyon

Address Waldorf, Md.

19. 11/19 1946 Edyria

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13, 1946, at 4:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1942 to 11-13 1946 and that I last saw her alive on Nov. 13, 1946

Immediate cause of death Cerebral Hemorrhage, severe 6 hours

Due to Hypertension 5 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank H. Susan M.D. or other

Address Indian Head, Md. Date signed 11-14-46

Permanently

ARTESIAN L. CO.

RAG CONTENT

RECEIVED
DEC 7 1944
H. B. B. B. B.

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (59)

CERTIFICATE OF DEATH

★10976
Reg. Dist. No. 1020

1. PLACE OF DEATH:

County CharlesCity or town Riverside
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town.....
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Infant - Henson (Lucie Ann)

3. (b) Social Security Number

4. Sex

5. Color or race

B.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

6.(c) If alive, give age..... years

7. Birth date of
deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Riverside, Charles Co. Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

Burial
(Burial, cremation, or removal, Which?)

Date thereof

Mar 17 1946
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

Mar 19 1946
(Date rec'd by registrar)

19

46

W. N. Thompson
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....Mar 16 1946 at 3:25 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....10..... to.....10.....

and that I last saw him.....alive on.....to.....

Immediate cause of death

DURATION

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

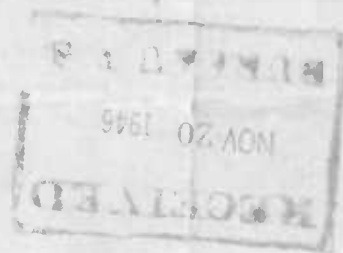
Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address.....Marbury Md Date signed.....Mar 17 1946



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

CERTIFICATE OF DEATH

10977

Reg. Dist. No. 1000

1. PLACE OF DEATH: Charles
 County Laplate Md.
 City or town Laplate Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? en-route to Hosp.
 Hospital, institution, or street address where death occurred:
Phys. Mem. Hosp. Laplate Md.
 How long in hospital or institution? deal on arrival

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County St. Marys
 City or town Mechanicville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME
Cecilia Mae Huntington

3. (b) Social Security Number
none

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced M.
 6. (b) Name of husband or wife Robert B. Huntington

7. Birth date of deceased (mo., day, yr.) May 27 1892 6. (c) If alive, give age _____ years

8. AGE: Years 54 Months 6 Days ✓ It less than one day _____ hrs. _____ min.

9. Birthplace St. Mary's Co Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business _____

12. Name George H. Farrell

13. Birthplace St. Mary's Co

14. Maiden name Terese Quade

15. Birthplace St. Mary's Co

16. Informant Lillian M. Hood (daughter)

Address Mechanicville Md.

17. Burial Date thereof 12-2-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Josephs

Location Maryland

18. Funeral director Chapman McFarland

Address Laplateville Md.

19. 11-30-46 19 _____
 (Date rec'd by registrar)

Julia H. Pacey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-29 1946 at 7A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____ to _____ 19 _____

and that I last saw him _____ live on _____ 19 _____

Immediate cause of death _____ DURATION _____

Coronary Thrombosis 11-29-46

Due to _____

Due to Generalized Arteriosclerosis

Other conditions Asthma Life

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE E. P. Pallen M. D. or other _____

Address Laplate Md. Date signed 11-29-46

RECEIVED

DEC 4 1946

BUREAU

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10978

Reg. Dist. No. 1050

1. PLACE OF DEATH *Charles*
County.....
City or town.....*Indian Head*
(if outside city or town limits, write RURAL and give nearest town)
How long in above place of death? *15 min.*
Hospital, institution, or street address where death occurred:
U.S. Naval Dispensary, Indian Head
How long in hospital or institution? *15 min.*

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State.....*Md.* County.....*Prince George*
City or town.....*Accokeek*
(if outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3.(a) FULL NAME *Joseph Alan Kenlon*

3.(b) Social Security Number

4. Sex *Male* 5. Color or race *White* 6.(a) Single, married, widowed, or divorced *Single*

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) *Oct. 11, 1944* 6.(c) If alive, give age..... years

8. AGE: Years *2* Months *1* Days *5* If less than one day..... hrs. min.

9. Birthplace.....*Accokeek*
(Town, county, and state)
Ch. Id.

10. Usual occupation.....

11. Industry or business.....*John*

12. Name.....*Joseph Wilbur Kenlon*

13. Birthplace.....*Accokeek Md*

14. Maiden name.....*Emma Hartson*

15. Birthplace.....*Baltimore Md*

16. Informant.....*John W. Kenlon*

Address.....*Accokeek, Md*

17. *Burial* Date thereof.....*11-8-46*
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory.....*Shiles*

Location.....*Shiles Md*

18. Funeral director.....*Hunt & Ryan*

Address.....*Weldort, Md*

19. *Nov 6* 19 *46* *M. P. Mowatt*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*November 6, 1946*, at *7:30* AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....19....., to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death.....*Congenital Heart Disease* DURATION *2 yrs.*

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Antopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....*Frank G. Snow M.D.* M. D. or other

Address.....*Indian Head Md* Date signed.....*11-6-46*

RECEIVED
OFC 7 1946
BUREAU T.S.

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 480

CERTIFICATE OF DEATH

★ 1979

Reg. Dist. No. 1000

1. PLACE OF DEATH:

County Charles
 City or town Hughesville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Charles
 City or town Hughesville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

MARIE MARTIN

3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Robert J. Martin
 B.(c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Nov. 9 1910

8. AGE: Years 35 Months 11 Days 28 If less than one day _____ hrs. _____ min.

9. Birthplace Charles Co., Md.
 (Town, county, and state)

10. Usual occupation House Wife

11. Industry or business _____

FATHER 12. Name Abraham Goldsmith
 13. Birthplace Charles Co., Md.

MOTHER 14. Maiden name Ida Goldsmith
 15. Birthplace Charles Co., Md

16. Informant Robert J. Martin
 Address Hughesville, Md.

17. Burial Date thereof Nov. 11 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Old Fields Cemetery
Hughesville, Md.
 Location _____

18. Funeral director Elmer M. Quade
 Address Hughesville, Md

19. 11-9-46 Julia H. Pacey
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7 1946 at 7:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1946 to Nov. 7 1946 and that I last saw her alive on Nov. 7 1946

Immediate cause of death Carcinoma of the Cervix of the uterus and the uterus
Ducts (Adenocarcinoma) DURATION 6 months

Due to _____
 Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations Adenocarcinoma of the cervix and uterus Date of op. Nov. 11, 1946

Autopsy results none
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Louis L. Garcia MD M. D. or other
 Address Hughesville, Md Date signed 11-9-46

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NOV 13 1946

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1312

CERTIFICATE OF DEATH

16980

Reg. Dist. No. 1000

1. PLACE OF DEATH:

County CharlesCity or town La Plata
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County CharlesCity or town La Plata
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Louis Andrew Norris

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) June 16, 1894

8. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

52427

_____ hrs.

_____ min.

9. Birthplace

Pomfret, Charles, md.
(Town, county, and state)

10. Usual occupation

Salesman

11. Industry or business

FATHER
MOTHER

12. Name

Julian E. Norris

13. Birthplace

Pomfret, md.

14. Maiden name

Helen A. La Motte

15. Birthplace

Hamstead, md.

16. Informant

Robert V. Norris

Address

La Plata, md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

11/14/46
(month) (day) (year)

Cemetery or crematory

St. Joseph's

Location

Pomfret, md.

18. Funeral director

Hunt & Ryon

Address

Waco, md.

19.

11-13
(Date rec'd by registrar)19 46Julius L. Parry
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12, 1946 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 29, 1946 to Nov. 12, 1946and that I last saw him alive on Nov. 11, 1946

Immediate cause of death

Renal arteriosclerosis
with uraemia

DURATION

3 mos.

Due to

Generalized arteriosclerosis
arteriosclerosis6 mos.

Died of

C" malignant hypertension"

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James E. Mackaway, M.D.
M. D. or other

Address

La Plata, md.Date signed 11-12-46

CERTIFICATE OF DEATH

2

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NOV 16 1961
BUREAU 18

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 330

CERTIFICATE OF DEATH

Reg. Dist. No. 1040

1. PLACE OF DEATH:

County CharlesCity or town Essex
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County CharlesCity or town _____
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

4. Sex

m

5. Color or race

W.

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Walter Oliver

7. Birth date of deceased (mo., day, yr.)

Jan, 14, 18926.(c) If alive, give age 53 years

8. AGE:

Years

Months

Days

If less than one day

54921

hrs.

min.

9. Birthplace

Charles, Md.
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER

12. Name

Walter Oliver

13. Birthplace

Buddle Creek

14. Maiden name

Daisy unknown

15. Birthplace

W. K. K. K. K.

18. Informant

William Oliver

Address

Essex

17.

reburied
(Burial, cremation, or removal. Which?)

Date thereof

11-7-46
(month) (day) (year)

Cemetery or crematory

Charles

Location

St Mary's Co. Md.

18. Funeral director

W. H. H. H. H.

Address

Waldorf

19.

11/5 46
(Date rec'd by registrar)William Oliver
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 4, 1946 at 5-P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 17, 1946 to Nov 4, 1946and that I last saw him alive on Nov 4, 1946Immediate cause of death apoplexy

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. P. H. H. H.

M. D. or other

Address

WaldorfDate signed Nov 5, 46

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NOV 6 1946
BUREAU
1-35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1862

CERTIFICATE OF DEATH

Reg. Diat. No. 1050

1. PLACE OF DEATH:

County Charles
 City or town Mt Victoria
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State md. County Charles
 City or town Mt Victoria
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Joseph Ralph Pilkerton

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced single
 6.(b) Name of husband or wife _____
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) July 30 - 1904
 8. AGE: Years 42 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Bryantown md
 (Town, county, and state)
 10. Usual occupation farmer
 11. Industry or business _____
 12. Name John Thomas Pilkerton
 13. Birthplace St Marys Co md
 14. Maiden name Agnes Regina Fleming
 15. Birthplace Bryantown md

16. Informant Louis J. Pilkerton
 Address Newberg md
 17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/1-5-46
 (month) (day) (year)
 Cemetery or crematory St Marys
 Location New Port md
 18. Funeral director Hunt & Ryan
 Address Wadsworth md
 19. Mr J. M. L. Moore Registrar
 (Date rec'd by registrar) 19 46

MEDICAL CERTIFICATION

20. DATE OF DEATH November 2, 1946 at 4:15 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from on
Sept 2, 1946 to Nov 2, 1946
 and that I last saw him in Nov 2, 1946
 Immediate cause of death Generalized peritonitis
 Due to Ulcerative cystitis
 Due to Accidental fracture-dislocation of thoracic spine with severed cord
 Other conditions _____

DURATION

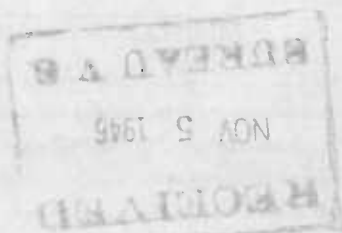
36 hrs.4 weeks2 months

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Accident Date of 9-2-46
 Where did injury occur? Mt Victoria, Charles, md
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) Farm
 Means of injury Fell from barn Injured at work? yes
 Deputy Medical Examiner
 23. SIGNATURE John L. Mackinrough, M.D. M. D. or other
 Address La Plata, Md. Date signed 11-2-46

1-35



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Charles
 City or town Waldorf md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State md County Charles
 City or town Waldorf md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

George Lafayette Robey
 4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Widowed

3. (b) Social Security Number

none

6. (b) Name of husband or wife

6. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) Dec 2-1859

8. AGE: Years 86 Months Days If less than one day
 hrs. min.

9. Birthplace Waldorf md
 (Town, county, and state)

10. Usual occupation Ret. Restaurant

11. Industry or business

12. Name Theodore Robey

13. Birthplace Waldorf md

14. Maiden name Caroline Willett

15. Birthplace Waldorf md

16. Informant Grace Robey

Address Waldorf md

17. Buried Date thereof 11-23-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Pauls Pines

Location Waldorf md

18. Funeral director Hunt & Ryan

Address Waldorf md
 19. 11-22 19 46 L. Snow
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/21 19 46 at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 46 to 11/21 19 46 and that I last saw him alive on 19

Immediate cause of death Myocardial
insufficiency

Due to Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. A. Waldorf M.D.
Waldorf, Md M. D. or other
 Address Date signed 11/22/46

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NOV 26 1946

BUREAU V B.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 16420

CERTIFICATE OF DEATH

10984

Reg. Dist. No. 106

1. PLACE OF DEATH:

County Charles
City or town Indian Head
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Chas.
City or town Indian Head, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2. (a) If veteran, name war.

3. (a) FULL NAME

3. (b) Social Security Number

Mason Sheehan
4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Mae L. Sheehan
6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) 9-11-14
8. AGE: Years 32 Months _____ Days _____ It less than one day _____ hrs. _____ min.

9. Birthplace Kansas
(Town, county, and state)
10. Usual occupation C. G. Machine U.S.N.
11. Industry or business U.S.N.

FATHER
12. Name Lawrence Joseph Sheehan
13. Birthplace Topeka, Kansas
MOTHER
14. Maiden name Bessie Carter
15. Birthplace Conistown, Kansas

16. Informant
Address

17. removal Date thereof Nov. 3, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Bethesda Naval Hospital
Location Bethesda, Md.

18. Funeral director Medical Officer U.S.N.
Address Indian Head, Md.

19. Nov. 3, 1946 Odey Price
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 2, 1946, at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19_____, to _____ 19_____, and that I last saw him _____ alive on _____ 19_____

Immediate cause of death Gunshot wound in Head
DURATION
Due to self inflicted while insane

Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide suicide Date of 11/2/46
Where did injury occur? Indian Head, Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? Work

23. SIGNATURE [Signature] M. D. or other
Address 2327 Indian Head Date signed 11-26-46

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The copy of this certificate is especially important. Physicians: please write the causes of death clearly and legibly.

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NOV 27 1946

BUREAU V &

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of year of birth is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 10985
1850
Reg. Dist. No.

FILM No. I 08 NOV 18 1946

1. PLACE OF DEATH:

County Charles
City or town Waldorf
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md. County Charles
City or town Waldorf
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

James Smith

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-9-02 1904

8. AGE: Years 42 Months Days If less than one day
hrs. min.

9. Birthplace Homestead Pa.
(Town, county, and state)
Carport

10. Usual occupation

11. Industry or business

12. Name William D. Smith

13. Birthplace Homestead Pa.

14. Maiden name Mary Mason

15. Birthplace Homestead Pa.

16. Informant Margaret Smith

Address 170 Lawrence St Steubenville Ohio

17. (Burial, cremation, or removal. Which?) Burial Date thereof 11-11-46
(month) (day) (year)

Cemetery or crematory Waldorf

Location Waldorf Md

18. Funeral director Waldorf Md

Address Waldorf Md

19. 10-11-10 19 46 M. L. Moore
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10, 1946 about 6:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from on
Nov. 10, 1946 to 1946

and that I last h. 10 on Nov. 10, 1946

Immediate cause of death 3rd degree burns

Due to accidental conflagration

Due to house burned down

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 11-10-46

Where did injury occur? Waldorf Charles Md
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury house burned down Injured at work? No
Dip. Med. Exam

23. SIGNATURE John L. Markham, M.D. M. D. or other

Address 82 Plaza Rd Date signed 11-10-46

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
JUN 13 1946
BUREAU V E

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 528

CERTIFICATE OF DEATH

Reg. Dist. No. 1000

1. PLACE OF DEATH:

County CharlesCity or town Newport
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residences of mother)

State Ind. County CharlesCity or town Newport
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife Geneva J. Tippet

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) April 5, 18728. AGE: Years 74 Months 7 Days 2 If less than one day _____ hrs. _____ min.9. Birthplace Chaptico, St. Marys, Md.
(Town, county, and state)10. Usual occupation Merchant

11. Industry or business

12. Name Robert Bruce Tippet13. Birthplace St. Marys co., Md.14. Maiden name Susan Cheseldine15. Birthplace St. Marys co., Md.16. Informant Mrs. Judson J. LongAddress Newport, Md.17. Burial (Burial, cremation, or removal, which?) Burial Date thereof 11/19/46
(month) (day) (year)Cemetery or crematory St. MarysLocation Newport, Md.18. Funeral director Huntt & RyanAddress Waldorf, Md.19. 14-8-46 19. _____
(Date rec'd by registrar)

Julia H. Percy Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-7-46 at 8:30 A.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-11-46 to 11-7-46and that I last saw him 11-6-46 alive on 11-6-46

Immediate cause of death

Cancer of Bladder

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Manner of injury _____ Injured at work?

23. SIGNATURE E. Odelen M.D. M.D. or otherAddress LaPlata Md. Date signed 11-8-46

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 17050

10987

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:

County Charles
City or town La Plata md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 days
Hospital, institution, or street address where death occurred:
Physicians Memorial Hospital
How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Charles
City or town Bel Air
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2. (a) If veteran, name war _____

3. (a) FULL NAME

Louise Van Warem

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced wid

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) April 14 - 1874

8. AGE: Years 72 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Washington DC
(Town, county, and state)

10. Usual occupation Cabinet maker

11. Industry or business

12. Name Theodore Van Warem
13. Birthplace France

14. Maiden name Marguerite Hall
15. Birthplace Ireland

16. Informant Theodore Vandoren
Address 2911 Morrison St, Wash DC

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof 11-26-46
(month) (day) (year)
Cemetery or crematory St Ignace's
Location Bel Air md

18. Funeral director Hunt & Ryon
Address Wadsworth md

19. 11-24 46 John H. Pacy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-23 1946 at 5 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-15 46 to 11-23 46
and that I last saw him alive on 11-23 46

Immediate cause of death Uremia
DURATION 11-18-46

Due to Crushing injuries
DUE TO Auto accident

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings of operations _____
Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of 11-15-46
Where did injury occur? Bel Air Charles md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Highway 301
Manner of injury Auto accident Injured at work? no

23. SIGNATURE B. J. Wilson M. J.
Address La Plata md Date signed 11-23-46

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

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NOV 27 1946

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1040

1. PLACE OF DEATH:

County... Charles

City or town... Rock Point
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Isaac Waters

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Helen Waters

7. Birth date of deceased (mo., day, yr.)

Aug. 12 - 1883

6. (c) If alive, give age

48 years

8. AGE:

Years

63

Months

2

Days

18

If less than one day

hrs.

min.

9. Birthplace

Fairmont Md.

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

John Waters

12. Name

Fairmont Md.

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Roch Point

Address

Location

18. Funeral director

Charles E. Hard

Address

Marion Station Md.

19. 10/4/46

(Date rec'd by registrar)

19. 10/4/46

(Date rec'd by registrar)

Registrar

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... Somerset

City or town... Fairmont
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4, 1946, at 1030

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 10 - 1946 to Nov. 4, 1946

and that I last saw him alive on Oct. 14 - 1946

Immediate cause of death

Cancer of Liver

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE J. R. Hayden

Address

Date signed Nov. 4, 46

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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NOV 6 1946
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2-35